DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 2002 — 08

2. STATE: Florida

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ -0-
b. FFY 2003 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D, Part I

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D, Part I

10. SUBJECT OF AMENDMENT:
Long Term Care Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bob Sharpe

13. TYPED NAME:
Mr. Bob Sharpe

14. TITLE:
Deputy Secretary

15. DATE SUBMITTED:
June 7, 2002

16. RETURN TO:
Mr. Bob Sharpe
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop # 20
Tallahassee, Florida 32308

Attn: Wendy Johnston

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
June 7, 2002

18. DATE APPROVED:
July 18, 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 1, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:
Rhonda K. Cottrell

21. TYPED NAME:
Rhonda K. Cottrell

22. TITLE: Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

FLORIDA TITLE XIX LONG-TERM CARE REIMBURSEMENT PLAN

VERSION XXII EFFECTIVE DATE: _____

I. Cost Finding and Cost Reporting

A. Each provider participating in the Florida Medicaid nursing home program shall submit a uniform cost report and related documents required by this plan using Agency for Health Care Administration (AHCA) form AHCA 5100-000, Rev. 7-1-90, as revised and prepared in accordance with the related instructions, postmarked or accepted by a common carrier no later than 3 calendar months after the close of its cost reporting year. Upon written request, AHCA shall grant an extension of time for filing cost reports. Three complete, legible copies of the cost report shall be submitted to AHCA, Bureau of Medicaid Program Analysis, Audit Services.

B. All providers are required to detail all of their costs for their entire reporting period, making appropriate adjustments as required by this plan for determination of allowable costs. For a new provider with no cost history in a newly constructed or existing facility entering the program or an existing provider in a newly constructed replacement facility, the interim operating and patient care cost per diems shall be the lesser of: the class reimbursement ceiling based on Section V of this Plan, the budgeted operating and patient care cost per diems approved by AHCA based on Section III of this plan, or the average operating and patient care per diems (excluding incentives) in the district in which the facility is located plus 50% of the difference between the average district per diem (excluding incentives) and the facility class ceiling. Existing providers in a newly constructed replacement facility shall receive the greater of the above operating and patient care cost per diems or their current operating and patient care per diems that are in effect prior to the operation of their replacement facility, not to exceed

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Effective 4/1/02
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the facility class ceilings. The average district per diem is calculated by taking the sum of all operating and patient care per diems divided by the number of facilities. Changes of ownership or of licensed operator do not qualify for increases in reimbursement rates associated with the change of ownership or of licensed operator. The Agency will provide that the initial nursing home reimbursement rates, for the operating, patient care, and MAR components, associated with related and unrelated party changes of ownership or licensed operator filed on or after September 1, 2001, are equivalent to the previous provider's reimbursement rate.

For a new provider with no cost history resulting from a change of ownership or operator, filed prior to September 1, 2001, where the previous provider participated in the Medicaid program, the interim operating and patient care per diems shall be the lesser of: the class reimbursement ceiling based on Section V of this Plan, the budgeted per diems approved by AHCA based on Section III of this Plan, or the previous providers' operating and patient care cost per diem (excluding incentives), plus 50% of the difference between the previous providers' per diem (excluding incentives) and the class ceiling. For a new provider with no cost history resulting from a change of ownership or operator filed on or after September 1, 2001, where the previous provider participated in the Medicaid program, the interim operating and patient care new provider ceilings shall be equivalent to the rates being paid to the previous provider for operating and patient care costs (excluding incentives). The above new provider ceilings, based on the district average per diem or the previous providers' per diem, shall apply to all new providers with a Medicaid certification effective on or after July 1, 1991. The new provider reimbursement limitation above, based on the district average per diem or the previous providers' per diem, which affects providers already in the Medicaid program, shall not apply to these same providers beginning with the rate

semester in which the target reimbursement provision in Section V.B.16. of this plan does not apply. This new provider reimbursement limitation shall apply to new providers entering the Medicaid program, even if the new provider enters the program during a rate semester in which Section V.B.16. of this plan does not apply. New provider ceilings applicable to the first rate semester a new provider enters the program shall be the basis for calculating subsequent rate semester new provider target ceilings for that same provider through the following calculation:

Effective July 1, 1996, except for only the January 1, 2000 and the January 1, 2002 rate semester for the patient care component, establish the target reimbursement for operating and patient care cost per diems for each provider by multiplying each provider's target reimbursement rate for operating and patient care cost in Step V.B.16. from the previous rate semester, excluding incentives and the Medicaid Adjustment Rate (MAR) with the quantity:

$$1 + 1.4 \times \left(\frac{\text{Florida Nursing Home Cost Inflation Index at the midpoint of the prospective rate period}}{\text{Florida Nursing Home Cost Inflation Index at the midpoint of the current rate period}} - 1 \right)$$

In the above calculation, the 1.4 shall be referred to as the inflation multiplier.

New providers limited by this section for the patient care component for the January 1, 2000 rate semester only shall be entitled to a similar adjustment in the inflation multiplier as described in Section V. B.16. For the January 1, 2002 rate semester, the direct and indirect subcomponents of the patient care per diem shall not be subject to the target reimbursement described above. For rate semesters subsequent to January 1, 2002, the indirect patient care subcomponent shall be limited to the target reimbursement described above, whereas the direct patient care subcomponent shall not be limited to the target reimbursement described above.

Providers on budget at December 31, 2001 shall have their interim patient care cost split into direct and indirect subcomponents based on a 65% and 35% split, respectively, for the January 1, 2002 rate semester. Upon submission of an initial cost report, the actual allocation of direct and indirect patient care costs will be adjusted through the cost settlement process.

New providers with no cost history resulting from a change of ownership or operator filed on or after September 1, 2001, where the previous provider participated in the Medicaid program, shall be eligible for the Medicaid Adjustment Rate (MAR). The interim MAR shall be equivalent to the prior providers' MAR. For new providers who enter the program operating a facility that had been previously operated by a Medicaid provider, the property reimbursement rate shall be established per Section V.E.4. of this plan. The property cost per diem for newly constructed facilities or replacement facilities shall be the lesser of: the budgeted fair rental value rate approved by AHCA based on Section V.E. of this plan; or the applicable fair rental value based upon the cost per bed standard that was in effect 6 months prior to the date the facility was first put in service as a nursing home. Return on equity or use allowance per diems shall be the budgeted rate approved by AHCA per Section III of this plan. Prospective reimbursement rates shall only be set on cost reports for periods of 6 months or more but less than 18 months. Cost reporting periods ending on or after July 1, 1991, shall be for periods 6 months or more but less than 18 months. Interim rates shall be cost settled for the interim rate period, and the cost settlement is subject to the above new provider reimbursement limitations. For changes of ownership or licensed operator filed on or after September 1, 2001 the provider will be required to file an initial cost report. For cost settlements related to changes of ownership or licensed operator filed on or after September 1, 2001, the new provider's operating target, patient care target, and MAR

rates will be limited to the operating, patient care, and MAR rates that were being paid to the previous provider.

C. The cost report shall be prepared by a Certified Public Accountant in accordance with Chapter 409.908, Florida Statutes, on the form prescribed in Section I.A., and on the accrual basis of accounting in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA) as incorporated by reference in Rule 61H1-20.007, F.A.C., the methods of reimbursement in accordance with Medicare (Title XVIII) Principles of Reimbursement, the Provider Reimbursement Manual (CMS-PUB.15-1) (1993) incorporated herein by reference except as modified by the Florida Title XIX Long Term Care Reimbursement Plan and State of Florida Administrative Rules. For governmental facilities operating on a cash method of accounting, data based on such a method of accounting shall be acceptable. The CPA preparing the cost report shall sign the cost report as the preparer, or, in a separate letter, state the scope of his work and opinion in conformity with generally accepted auditing standards as incorporated by reference in Rule 61H1-20.008, F.A.C., and AICPA statements on auditing standards. Cost reports, which are not signed by a Certified Public Accountant, or are not accompanied by a separate letter signed by a CPA, shall not be accepted.

D. Effective for January 1, 2002 rate setting, providers with a fiscal year ending on or before March 31, 2001, may elect, without prior approval from the Agency for Health Care Administration, to change their current fiscal year end and file a new cost report for a period of not less than six months. Should a provider elect to change their current fiscal year end and file a new cost report, then cost reports filed for the next two years must have the same year end.

E. All prior year cost reports must be submitted to and accepted by the Agency, before the current year cost report may be accepted for rate setting. If a provider submits a cost report late, after 3 calendar months, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been submitted within 3 calendar months, then the providers' rate for that rate semester shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be effected retroactively. The lower rate shall not be paid retroactively if the provider adequately demonstrates, through documentation, that emergency circumstances prevented the provider from submitting the cost report within the prescribed deadline. Similarly, if a provider submits a cost report late because of emergency circumstances, and the use of that cost report would have resulted in higher reimbursement for a rate semester had it been submitted within 3 calendar months, then the provider's rate for that rate semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Emergency circumstances are limited to loss of records from fire, flood, theft or wind.

F. A provider which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a final cost report in accordance with Section 2414.2, CMS-PUB.15-1 (1993) when that provider has been receiving an interim reimbursement rate.All providers are required to maintain financial and statistical records in accordance with 42 CFR 413.24 (2000), sections (a), (b), (c), and (e). The cost report is to be based on financial and statistical records maintained by the facility. Cost information shall be current, accurate, and in sufficient detail to support costs set forth in the report. This includes all ledgers, books, records, original evidence of cost and other records in accordance with CMS PUB. 15-1 (993) which pertain to the determination of reasonable costs, and shall be capable of and available for

auditing by State and Federal authorities. All accounting and other records shall be brought up to date at the end of each fiscal quarter. These records shall be retained by the provider for a minimum of 5 years following the date of submission of the cost report form to AHCA.

G. Records of related organizations as identified by 42 CFR 413.17 (2000) shall be available upon demand to representatives, employees, or contractors of AHCA, the Auditor General, General Accounting Office (GAO), or Department of Health and Human Services (HHS).

H. AHCA shall retain all uniform cost reports submitted for a period of at least 3 years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 42 CFR 431.17 (2000). Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes.

I. Chart of Accounts: For cost reports filed for the cost reporting periods ending on or after December 31, 2002, all providers must use the standard chart of accounts (ACHA Document Number 5300-0001 APR 02) to govern the content and manner of the presentation of financial information to be submitted by Medicaid long-term care providers in their cost reports. The standard chart of accounts includes specific accounts for each component of direct care staff by type of personnel and may not be revised without the written consent of the Auditor General.

II. Audits and Desk Reviews

Cost reports submitted by providers of nursing home care in accordance with this Plan are subject to an audit or desk review on a random basis and at any time the agency has been informed or has reason to believe that a provider has claimed or is claiming reimbursement for unallowable costs. The performance of a desk review does not preclude the performance of an audit at a later date.

A. Description of AHCA's Procedures for Audits-General

1. Primary responsibility for the audit of providers shall be borne by AHCA. The efforts of AHCA audit staff may be augmented by contracts with CPA firms to ensure that the requirements of 42 CFR 447.202 (2000) will be met.

2. All audits shall be based on generally accepted auditing standards as incorporated by reference in Rule 61H1-20.008, F.A.C., of the AICPA.

3. Upon completion of each audit, the auditors shall issue a report which meets the requirements of 42 CFR 447.202 (2000) and generally accepted auditing standards as incorporated by reference in Rule 61H1- 20.008, F.A.C. The Auditor shall declare an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all Federal and State regulations pertaining to the reimbursement program for long-term care facilities. All reports shall be retained by AHCA for 3 years.

4. The provider's copy of the audit report shall include all audit adjustments and changes and the authority for each, and all audit findings and shall be accompanied by such other documentation as is necessary to clarify such adjustments or findings.

B. Field Audit and Desk Review Procedures upon receipt of a cost report from the provider prepared in accordance with instructions furnished by the agency, the agency will determine whether an audit or desk review is to be performed. Providers selected for audit or desk review will be notified in writing by the AHCA Audit Office or CPA firm assigned to perform the audit or desk review.

1. Upon completion of an audit or desk review and before publication of the audit of desk review report, the provider shall be given an exit conference at which all findings will be discussed and explained. A copy of the proposed audit

or desk review adjustments will be given to the provider at least ten (10) days before the exit conference. If the provider fails to schedule an exit conference within twenty calendar days of receipt of the adjustments, the audit or desk review report will be issued without an exit conference. Desk review exit conferences will be conducted through the mail or in the agency's office in Tallahassee.

2. Following the exit conference, the provider has sixty (60) calendar days to submit documentation or other evidence to contest any disallowed expenditures or other adjustments. For adjustments made due to lack of adequate documentation or lack of support, any documentation received after the sixty-day period shall not be considered when revising adjustments made due to lack of adequate documentation or lack of support. However, the sixty-day limitation shall not apply if the provider can adequately demonstrate, through documentation, that emergency circumstances prevented the provider from submitting additional documentation within the prescribed deadline. Emergency circumstances are limited to loss of records from fire, wind, flood or theft.

3. All audit or desk review reports shall be issued by certified mail, return receipt requested and shall be mailed to the address of the nursing home to the attention of the administrator. The provider shall have twenty-one (21) calendar days from the date of receipt of the audit report to challenge any audit or desk review adjustment or audit or desk review finding contained in the report by requesting an administrative hearing in accordance with Section 120.57, Florida Statutes and Chapter 28.106, Florida Administrative Code. The audit or desk review report shall constitute prima facie evidence of the propriety of the adjustments contained therein. The burden of proof is upon the provider to affirmatively

demonstrate the entitlement to the Medicaid reimbursement. Except as otherwise provided this Plan, Chapter 28-106, Florida Administrative Code shall be applicable to any administrative proceeding under this Plan.

4. Collection of overpayments or refunds of amounts collected in error will be in accordance with Section 414.41, Florida Statutes and Rule 59G-9.010.

III. Allowable Costs

A. All items of expense shall be included on the cost report which providers must incur in meeting:

1. The definition of nursing facilities contained in Sections 1919(a), (b), (c), and (d) of the Social Security Act.
2. The standards prescribed by the Secretary of HHS for nursing facilities in regulations under the Social Security Act in 42 CFR 483 (2000), Subpart B.
3. The requirements established by AHCA which is responsible for establishing and maintaining health standards, under the authority of 42 CFR 431.610 (2000); and

B. All therapy required by 42 CFR 409.33 (1999) and Medicare or Medicaid certification standards and prescribed by the physician of record shall be considered as covered services and all costs, direct or indirect, shall be included in the cost report. These therapies include physical therapy, audiology, speech pathology and occupational therapy.

C. Implicit in any definition of allowable costs is that those costs shall not exceed what a prudent and cost-conscious buyer pays for a given service or item. If costs are

determined by AHCA, utilizing the Title XVIII Principles of Reimbursement, CMS-PUB.15-1 (1993) and this plan, to exceed the level that a prudent buyer would incur, then the excess costs shall not be reimbursable under the plan.

D. All items of expense, which providers incur in the provision of routine services, such as the regular room, dietary and nursing services, minor medical and surgical supplies, and the use of equipment and facilities, are allowable. A comprehensive listing of these items is available in the Nursing Facilities Limitations Handbook. The following are examples of expenses that allowable costs for routine services shall include:

(1) All general nursing services, for example: oxygen and related medications, hand feeding, incontinency care, tray service, and enemas;

(2) Items furnished routinely and relatively uniformly to all patients, such as patient gowns, water pitchers, basins, and bedpans;

(3) Items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol, applicators, cotton balls, adhesive bandages, antacids, aspirin and other non-legend drugs ordinarily kept on hand, suppositories, and tongue depressors;

(4) Items used by individual patients but which are reusable and expected to be available, such as ice bags, bedrails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable medical equipment;

(5) Special dietary supplements used for tube feeding or oral feeding, such as elemental high nitrogen diet, even if written as a prescription item by a physician because these supplements have been classified by the Food and Drug Administration as a food rather than a drug; and

(6) Laundry services other than for personal clothing, prior to October 1, 1993.

(7) Effective October 1, 1993, laundry services, including basic personal laundry services, but excluding dry cleaning, mending, hand washing or other specialty services, shall be an allowable cost.

E. Bad debts other than Title XIX, charity, and courtesy allowances shall not be included in allowable costs. Bad debts for Title XIX shall be limited to Title XIX uncollectible deductible and co-payments and the uncollectible portion of eligible Medicaid recipients' responsibilities. Example: Daily rate is $34.00; State pays $26.00 and patient is to pay $8.00. If Medicaid patient pays only $6.00, then $2.00 would be an allowable bad debt. All Medicaid Title XIX bad debts shown on a cost report shall be supported by proof of collection efforts, such as copies of two collection letters, etc.

F. Costs applicable to services, facilities, and supplies furnished to a provider by organizations related to a provider by common ownership or control shall be governed by Medicare (Title XVIII) Principles of Reimbursement, and Chapter 10, CMS-PUB.15-1 (1993). Providers shall identify such related organizations and costs in their cost reports.

G. Costs, which are otherwise allowable, shall be limited by the following provisions:

1. The Owner-Administrator and Owner-Assistant Administrator compensation shall be limited to reasonable levels determined in accordance with CMS-PUB.15-1 (1993) or determined by surveyed ranges of compensation conducted by AHCA. The survey shall be of all administrators and assistant administrators of Florida long-term care facilities, and shall, to the extent feasible with the survey data collected, recognize differences in organization, size, experience, length of service, services administered, and other distinguishing characteristics. Results of surveys and salary limitations shall be furnished to providers when the survey results are completed, and survey results shall be updated each year by

the wage and salary component of the plan's inflation index. A new salary survey shall be conducted every 3 years.

2. Limitation of rents:

   a. For the purposes of this provision, allowable ownership costs of leased property shall be defined as:

      (1) Cost of depreciable assets, property taxes on personal and real property, and property insurance;

      (2) Sales tax on lease payments except in cases of related parties; and

      (3) Return on equity that would be paid to the owner if he were the provider, as per Section J. below.

   b. Lease costs allowed for lease contracts existing as of August 31, 1984 shall remain unchanged except for increases specified in the contract entered into by the lessee and lessor before September 1, 1984. If, prior to October 1, 1985, the lessee exercises an option to renew the lease that existed as of August 31, 1984, increases in lease cost for each year of the renewal period shall be limited to the increase in the Florida Construction Cost Inflation Index (See Appendix B), used for property cost ceiling calculations in Section V., during the last 12 months. Lease cost increases shall be further limited to a maximum of 20 percent over 5 years. When the lease contract in effect on September 30, 1985 expires, including only options to renew which were exercised prior to October 1, 1985, reimbursement for lease costs and other property costs shall be based on a fair rental value system (FRVS) for the facility per Section V.E.1.a.-g. of this plan.

c. (1) For facilities that were not leased as of August 31, 1984 and that are operating under a lease agreement commencing on or after September 1, 1984 and before October 1, 1985, the Medicaid rent reimbursement shall be based on the lesser of actual rent paid or the allowable ownership costs of the leased property per Section III.G.3.-5.

(2) Annual increases in lease costs for providers in (l) above shall be limited to the increase in the Florida Construction Cost Inflation Index, used for property cost ceiling calculations in Section V, during the last 12 months. Lease cost increases shall be further limited to a maximum of 20 percent over 5 years. When the lease contract in effect on September 30, 1985 expires, including only options to renew which were exercised prior to October 1, 1985, reimbursement for lease costs and other property costs shall be based on a fair rental value system (FRVS) for the facility per Section V.E.1.a.-g. of this plan.

d. (1) Facilities leased on or after October 1, 1985 shall be reimbursed for lease costs and other property costs based on the FRVS per Section V.E.1.a.-g. of this plan. Allowable ownership costs shall be documented to AHCA for purposes of computing the fair rental value.

Facilities not reimbursed based on the FRVS per Section V.E.1.a.- g. of this plan shall not be reimbursed based on the FRVS per Section V.E.1.a.- g. of this plan, solely due to the

execution of a lease agreement between related organizations under Section III.F. of this plan.

(2) In no case shall Medicaid reimburse property costs of a provider who is subject to b., c., and d. (1) above and e. below if ownership costs are not properly documented per the provisions of this plan. Providers shall not be reimbursed for property costs if proper documentation, capable of being verified by an auditor, of the owner's costs is not submitted to AHCA. The owner shall be required to sign a letter to AHCA that states that the documentation submitted presents to the best of his knowledge true and correct information. The letter signed by the owner shall also state that the owner agrees to make his books and records of original entry related to the nursing home properties available to auditors or official representatives of AHCA.

(3) Approval shall not be given for a proof of financial ability for a provider if the provider is leasing the facility and does not submit the documentation of the owner's costs with the letter signed by the owner as per (2) above.

e. A lease agreement may be assigned and transferred (assumed) for Medicaid reimbursement purposes if all of the following criteria are met:

(1) The lease agreement was executed prior to September 1, 1984 (when the "limitations of rents" provisions were implemented).

(2) The lease cost is allowable for Medicaid reimbursement purposes.

(3) The lease agreement includes provisions that allow for the assignment.

(4) All provisions (terms, payment rates, etc.) of the lease agreement remained unchanged (only the lessee changes).

When the assumed lease contract in effect on September 30, 1985, expires, including only options to renew which were exercised prior to October 1, 1985, reimbursement for lease costs and other property costs shall be based on a FRVS for the facility per Section V.E.1.a.-g. of this plan.

3. Basis for depreciation and calculation:

a. Cost.

Historical cost of long-term care facilities shall be the basis for calculating depreciation as an allowable cost, except as provided by 3b. and 6. below. All provisions of the Medicare (Title XVIII) Principles of Reimbursement and CMS-PUB.15-1 (1993) regarding asset cost finding shall be followed.

b. Change in ownership of depreciable assets. For purposes of this plan, a change in ownership of assets occurs when unrelated parties: purchase the depreciable assets of the facility; or purchase 100 percent of the stock of the facility and within 1 year merge the purchased facility into an existing corporate structure or liquidate the purchased corporation and create a new corporation to operate as the provider. In a case in which a change in ownership of a provider's or the lessor's depreciable assets occurs, and if a bona fide sale is established, the basis for depreciation shall be the lower of:

1) The fair market value of the depreciable facility as defined by 42 CFR 413.134 (2000) and determined by an appraiser who meets the requirements of Section 59A-4.103 (6) (I) 9. b. Florida Administrative Code;

2) The allowable acquisition cost of the assets to the owner of record on July 18, 1984, for facilities operating on that date, or the first owner of record for facilities that begin operation after July 18, 1984; or

3) The acquisition cost of such assets to the new owner.

Example 1: An owner, who is the owner of record on July 18, 1984, has a facility with a historical depreciable basis of $500,000.00. A new owner purchases the facility for $1,000,000.00. The new owner's basis for depreciation is the lesser of the two, or $500,000.00.

Example 2: An owner, who is the owner of record on July 18, 1984, has a facility with a historical depreciable basis of $500,000.00. A new owner purchases the facility for $300,000.00. The new owner's basis for depreciation is the lesser of the two, or $300,000.00.

4. Limitation on interest expense for property-related debt and on return on equity or use allowance. At a change of ownership on or after July 18, 1984, the interest cost and return on equity or use allowance to the new owner shall be limited by the allowable basis for depreciation as defined per 3.b. above. The new owner shall be allowed the lesser of actual costs or interest cost and return on equity cost or use allowance in amounts that would have occurred based on

the allowable depreciable basis of the assets. These limited amounts shall be determined as follows:

a. The portion of the equity balance that represents the owner's investment in the capital assets shall be limited for purposes of calculating a return on equity or use allowance to the total amount allowed as depreciable basis for those assets as per 3.b. above.

b. The amount of interest cost due to debt financing of the capital assets shall be limited to the amount calculated on the remainder of the allowable depreciable basis after reducing that allowable basis by the amount allowed for equity in a. above. The new owner's current terms of financing shall be used for purposes of this provision.

Example 1: The first owner of record after July 18, 1984 has an acquisition cost of $600,000.00. The new owner pays $1,000,000.00 for the facility, makes a down payment of $200,000.00 and finances $800,000.00 at 15 percent for 25 years. The basis for depreciation to the new owner is $600,000.00, and the disallowed portion of the depreciable basis is $400,000.00. Therefore, the allowable equity attributable to investment in the capital assets is $200,000.00, and interest cost allowed shall be computed on $400,000.00 ($600,000.00 minus $200,000.00) at 15 percent over 25 years.

Example 2: If the new owner above had made a down payment of $700,000.00 and financed $300,000.00, the allowable equity would be $600,000.00, and no interest cost would be allowed.

5. Costs attributable to the negotiation or settlement of a sale or purchase of a facility occurring on or after July 18, 1984 shall not be considered allowable

costs for Medicaid reimbursement purposes to the extent that such costs were previously reimbursed for that facility under a former owner. Such costs include legal fees, accounting fees, administrative costs, travel costs, and costs of feasibility studies, but do not include costs of tangible assets, financing costs, or other soft costs.

6. Capital costs which require certificate of need (CON) approval shall be allowed for reimbursement purposes only if the capital expenditure receives approval from the CON office. All cost overruns which require CON approval must also be approved in order to qualify for reimbursement. This section will apply to all providers with Medicaid certification effective on or after July 1, 1991.

	Example 1	**Example 2**
New Facility Cost	$3.0 Million	$4.0 Million
CON Approval	$2.8 Million	$3.0 Million
Medicaid Allowable Cost	$2.5 Million	$3.5 Million
Reimbursable Cost	$2.5 Million	$3.0 Million

Total capital expenditures which are greater than the total amount approved by CON shall not be recognized for reimbursement purposes. In the example above, the reimbursable cost which is considered in rate calculations, is the lower of the new facility cost, CON approval, or the Medicaid allowable cost.

H. Recapture of depreciation resulting from sale of assets.

1. The sale of depreciable assets, or substantial portion thereof, at a price in excess of the cost of the property as reduced by accumulated depreciation, resulting in a gain on sale, and calculated in accordance with Medicare (Title XVIII) Principles of Reimbursement, indicates